

**H. BILLING FOR SERVICES TO CHILDREN NOT IN A MCO (FEE-FOR-SERVICE)**

Providers will find that most children are enrolled in a Managed Care Organization (MCO). However, if the patient is not in a MCO, bill the Medical Assistance/Medicaid Fee-For-Service (FFS) Program. To participate in the Medicaid Program, apply online at <http://www.emdhealthchoice.org>.

All rendering providers, solo practices and group practices must have a **National Provider Identifier (NPI)**, a 10-digit, numeric identifier that does not expire or change. NPI is a HIPAA mandate requiring a standard unique identifier for health care providers. It is administered by the Centers for Medicare and Medicaid Services (CMS). Additional information on NPI can be obtained from the CMS website at: <http://www.cms.hhs.gov/NationalProvIdentStand/>. **Providers must use the NPI on all electronic transactions. When a provider bills on paper, the NPI number and the provider's 9-digit Medicaid provider number will be required in order to be reimbursed appropriately.**

Providers should apply online for NPIs through the National Plan and Provider Enumeration System (NPPES) at [nppes.cms.hhs.gov/NPPES/Welcome](http://nppes.cms.hhs.gov/NPPES/Welcome). A paper application is available at: <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms10114.pdf>.

Submit completed, signed paper copies of the NPI Application/Update Form (**CMS-10114**) to the NPI Enumerator at the address below:

NPI Enumerator  
P.O. Box 6059  
Fargo, ND 58108-6059  
1-800-465-3203

[customerservice@npienumerator.com](mailto:customerservice@npienumerator.com)

All rendering providers, solo practices and group practices must also have a valid Medical Assistance (MA) provider number. For assistance or to determine the status of the MA number or application, call **Provider Enrollment Support** at **410-767-5340**.

Follow the general billing practices noted in the *Physicians' Services Provider Fee Manual* and the most current *Physicians' Services Provider Fee Schedule*. Contact the **Provider Relations Unit** at **410-767-5503** or **1-800-445-1159** to request these materials or access information on the following DHMH webpage: [www.dhmh.maryland.gov/providerinfo](http://www.dhmh.maryland.gov/providerinfo).

Always refer to your copy of the *Current Procedural Terminology (CPT)* edition published yearly by the *American Medical Association* to verify current codes. For more information on AMA products, please call **1-800-621-8335** or visit:

<http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page>.

### Preventive Medicine Services Codes

The EPSDT program uses the following Preventive Medicine (full screening) CPT codes for billing well-child care.

- New Patient/Full Screening: 99381 – 99385 – A full screening includes a health and developmental history, unclothed physical exam, appropriate laboratory tests, immunizations and health education/anticipatory guidance. Note: A newborn infant history and examination completed in a hospital should be billed using CPT newborn care code 99460.
- Established Patient/Full Screening: 99391 – 99395 – A full periodic screening is completed on an established patient at subsequent intervals according to the age intervals on the [Maryland Healthy Kids Preventive Care Schedule](#) (Refer to Section 2).

Preventive Medicine CPT codes are also used to report a full EPSDT screening provided in a hospital outpatient department setting (when the physician's services are not included in the cost-based hospital rate) and for patients who are in the care and custody of a State agency pursuant to a court order or a voluntary placement agreement.

See the Table below for specific codes. For fee schedule, refer to the most current *Medicaid Provider Fee Schedule Manual* at [www.dhmf.maryland.gov/providerinfo](http://www.dhmf.maryland.gov/providerinfo).

Table 4: Preventive Medicine CPT Codes	
Procedure	CPT Code
<i>Comprehensive Preventive Medicine (New Patient)</i>	
New patient 0 – 11 months	99381
New patient 1 – 4 years	99382
New patient 5 – 11 years	99383
New patient 12 – 17 years	99384
New patient 18 – 39 years	99385
<i>Comprehensive Preventive Medicine (Established Patient)</i>	
Established patient 0 – 12 months	99391
Established patient 1 – 4 years	99392
Established patient 5 – 11 years	99393
Established patient 12 – 17 years	99394

If a child presents for a problem-oriented visit and the child is due for a preventive visit, it is recommended that the provider complete the Healthy Kids preventive care in addition to rendering care for the presenting problem, and use the appropriate CPT preventive code. However, providers cannot bill for a “problem-oriented” and preventive visit for the same child, on the same day. If only “problem-oriented” care is rendered, use the appropriate Evaluation and Management (E&M) CPT codes for time and level of complexity.

Under certain situations, a preventive exam and another E&M service may be payable on the same day. In this case, providers should select the most appropriate single E&M service based on all services provided. If an abnormality is encountered or a preexisting problem is addressed in the process of performing a preventative E&M services, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E&M service, then the appropriate office/outpatient code should also be reported. Insignificant or trivial abnormality should not be reported.

Modifier-25 should be added to the office/outpatient code to indicate that a significant, separately identifiable E&M service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.

Oral health assessment by the Primary Care Provider (PCP) is included in the preventive code as part of the Healthy Kids preventive care examination. Dentists, however, should consult [Scion Dental, Inc.](#)<sup>1</sup> at 1- 844-275-8753 regarding coding for dental services.

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<sup>1</sup> See [provider.MDhealthysmiles.com](#).

## Section 6

## Billing and Encounter Data Reporting

### Objective Hearing and Vision Tests, Substance Use, and Developmental Screening

Objective hearing and vision tests can be billed in addition to the preventive screen. Providers can also bill separately for developmental screening with an approved or recommended standardized, validated general developmental screening tool (Refer to Section 3, Addendum) during either a preventive or episodic visit using CPT code 96110 (see below). CPT 96111 should be used for a longer, more comprehensive developmental evaluation performed by a physician or other specially trained professional.

See the Table below for specific codes. For fee schedule, refer to the most current *Medicaid Provider Fee Schedule Manual* at [www.dhmf.maryland.gov/providerinfo](http://www.dhmf.maryland.gov/providerinfo).

<b>Table 5: Objective Hearing &amp; Vision Tests, Substance Use and Development Screening CPT Codes</b>	
<b>Procedure</b>	<b>CPT Code</b>
Hearing/Screening test, pure air only	92551
Visual screening test	99173
Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes and up to 10 minutes	99406
Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	99407
Alcohol and/or substance (other than tobacco) use disorder screening, self-administered	W7000 <sup>1</sup>
Alcohol and/or substance (other than tobacco) use disorder screening; provider-administered structured screening(e.g., AUDIT, DAST)	W7010 <sup>1</sup>
Alcohol and/or substance (other than tobacco) use disorder intervention; greater than 3 minutes up to 10 minutes	W7020 <sup>1</sup>
Alcohol and/or substance (other than tobacco) use disorder intervention; greater than 10 minutes up to 20 minutes	W7021 <sup>1</sup>
Alcohol and /or substance (other than tobacco) use disorder intervention; greater than 20 minutes	99409 <sup>2</sup>
Developmental testing: Limited (e.g., Ages and Stages Questionnaire, Pediatric Evaluation of Developmental Status) with Interpretation and Report*	96110 <sup>2,3,4</sup>
Developmental Testing: Extended (Includes Assessment of Motor, Language, Social, Adaptive and/or Cognitive Functioning by	96111

<b>Table 5: Objective Hearing &amp; Vision Tests, Substance Use and Development Screening CPT Codes</b>	
<b>Procedure</b>	<b>CPT Code</b>
Standardized Developmental Instruments, e.g., Bayley Scales of Infant Development with Interpretation and Report	

<sup>1</sup>The Department will pay a provider for a maximum of one screening and four (4) interventions annually per recipient ages 12-20. Providers cannot bill more than one screening code on the same claim for the same patient on the same day. However, if a screening and intervention are completed on the same day, they may be billed on the same claim. If a self-screen and a provider screen are performed in the same day, Maryland Medical Assistance will pay whichever is billed first. Providers do not need to bill for a significant, separately identifiable E&M service on the same day as performing an intervention service.

<sup>2</sup>A standardized, validated tool must be used.

<sup>3</sup>For FFS patients: Providers may bill a maximum of two (2) units of CPT 96110 on the same date of service when a screening tool for autism or a social-emotional screening (e.g., ASQ-SE) is administered in addition to a general developmental screening tool.

<sup>4</sup>For MCO patients: If providers bill for more than one unit of services, they must use modifier “59” following the CPT code. Modifier 59 is used to identify procedures/services, other than E&M services, that are not normally reported together, but are appropriate under the circumstance

\*Documentation for developmental screening should include:

- Any parental concerns about the child’s development,
- The name of screening tool used,
- The screening tool results, reviewing all major areas of development,
- An overall result of the development assessment for age (e.g., normal, abnormal, needs further evaluation), and
- A plan for referral or further evaluation when indicated.

**Laboratory Services**

All providers billing for any laboratory service(s) must be CLIA certified and approved by the Maryland Laboratory Administration, if located in Maryland. Contact the **Division of Hospital and Physician Services at 410-767-1462** for information regarding CLIA certification. Interpretation of laboratory results, or the taking of specimens other than blood, is considered part of the office visit and may not be billed as a separate procedure. Specimen collection for Pap smears and PKU (Phenylketonuria) for infants is not billable by a physician

See the Table below for specific laboratory services CPT codes frequently billed in addition to the Healthy Kids preventive code. For fee schedule, refer to the most current *Medicaid Provider Fee Schedule Manual* at [www.dhmf.maryland.gov/providerinfo](http://www.dhmf.maryland.gov/providerinfo).

<b>Table 6: Laboratory Services CPT Codes</b>	
<b>Procedure</b>	<b>CPT Code</b>
Venipuncture under 3 yrs, physician skill (e.g., blood lead)	36406
Venipuncture, physician skill, child 3 yrs and over (e.g., blood lead)	36410
Venipuncture, non-physician skill, all ages	36415
Capillary blood specimen collection, finger, heel, earstick (e.g. PKU, blood lead filter paper, hematocrit)	36416
Urinalysis/microscopy	81000
Urine Microscopy	81015
Urine Dipstick	81005
Urine Culture (Female Only)	87086
Hematocrit (spun)	85013
Hemoglobin	85018
PPD – Mantoux	86580

**Evaluation and Management Office Visits (E&M) Codes**

Generally, CPT descriptions for E&M services indicate “per day” and only one E&M service may be reported per date of service. Modifier - 21 for prolonged E&M service is informational only and does not affect payment. Providers cannot bill for a “problem-oriented” and preventive visit for the same child, on the same day. The comprehensive nature of the preventive medicine services codes (99381-99394), however, reflects an age and gender appropriate history/exam and is not synonymous with the “comprehensive” examination required in E&M codes (99201-99215). Under certain situations, a preventive exam and another E&M service may be payable on the same day. Modifier-25 should be added to the office/outpatient code to indicate that the same physician provided significant, separately identifiable E&M services on the same day as the preventive medicine services. The applicable preventative medicine service is additionally reported.

See specific E&M codes in Table 7 below. For fee schedule, see the most current *Medicaid Provider Fee Schedule Manual* at [www.dhmf.maryland.gov/providerinfo](http://www.dhmf.maryland.gov/providerinfo).

<b>Table 7: Evaluation &amp; Management Office Visit Codes</b>	
<b>Procedure</b>	<b>CPT Code</b>
New patient (10 minutes)	99201
New patient (20 minutes)	99202
New patient (30 minutes)	99203
New patient (45 minutes)	99204
New patient (60 minutes)	99205
Established patient (5 minutes) <sup>1</sup>	99211
Established patient (10 minutes)	99212
Established patient (15 minutes)	99213
Established patient (25 minutes)	99214
Established patient (40 minutes)	99215

<sup>1</sup> E&M “that may not require the presence of a physician”

